**IN THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF NEW YORK**

| | |
|---|---|
| **IN RE: FOSAMAX PRODUCTS LIABILITY LITIGATION (MDL No. 1789)** | **JUDGE KEENAN** |
| | **Plaintiff:** Tamaris Reyes-Hernandez |
| | **SDNY Case No.** _____ |

## PLAINTIFF PROFILE FORM

Please provide the following information regarding yourself or each individual on whose behalf a personal injury or dental or other monitoring claim is being made. Each question must be answered in full. If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. To the extent you cannot completely answer any question, please provide whatever information is available to you and, as to any information sought by the question which you do not know, please identify what part of the question you cannot answer. Do not leave any questions unanswered or blank.

Please attach as many sheets of paper as necessary to fully answer these questions.

In filling out this form, please use the following definitions:

(1) "**health care provider**" or "**health care practitioner**" means any hospital, clinic, center, physician's office, dentist's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, oral, psychiatric, mental, emotional or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, dentist, oral and maxillofacial surgeon pathologist, oral pathologist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, dental, oral, radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;

(2) "**document**" means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into any reasonably usable form.

(3) "**Fosamax**" means FOSAMAX® and FOSAMAX PLUS D®.

(4) "**Osteonecrosis of the jaw**" includes "avascular necrosis of the jaw," "aseptic necrosis of the jaw," and "ischemic necrosis of the jaw."

Other than in Section I(C), those questions using the term "You" should refer to the person who used Fosamax. You should attach as many sheets of paper as necessary to fully answer these questions.

If you have any documents (as defined above), that you are requested to produce in response to questions in this profile form or that relate to Fosamax or other bisphosphonate-containing products or medications you allegedly took, or to the incident, injuries, claims or damages that are the subject of your complaint or, if you have any unused Fosamax and its accompanying packaging, you are required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about this obligation, please contact your attorney.

Whenever you are asked for the name and address of an individual or entity, you are to provide the full name and complete address for that individual or entity.

## I. CASE INFORMATION

A. Name of person completing this form Tamari Reyes Hernandez

B. Please state the following for the civil action which you have filed:

1. Case Caption: _____

2. Case No.: _____

3. Please state the name, address, and telephone number of the principal attorney representing you:

Eduardo Rodriguez
Name of attorney

Law Offices of Kim, Pardy + Rodriguez, P.A.
Firm name

230 East Marks St. Orlando Fla 32803
City, State and Zip Code

(407) 481-0066
Telephone number

C. If you are completing this questionnaire on behalf of someone else (*e.g.*, a deceased person, an incapacitated person), please complete the following:

_____
Your Name

_____
Address

_____
Social Security Number

In what capacity are you representing the individual? _____

_____

If you were appointed by a court, please provide a copy of the order of appointment or power of attorney/authorizing document and state the:

_____

Court Date of Appointment

What is your relationship to the deceased or represented person? ____

_____

If you represent a decedent's estate, state the date of the decedent's death:_____

D. Claim Information

1. Do you claim that you have suffered a physical injury as a result of Fosamax use? Yes ✓ No _____

2. If the answer to the foregoing question is "yes," state the nature of the physical injury or injuries which you claim.

✓ Osteonecrosis of the Jaw
___ Osteomyelitis of the Jaw
___ Increased Risk of Developing Osteonecrosis of the Jaw
___ Other (Please Specify): _____
___ Not claiming any physical injuries as a result of Fosamax use

a. When do you claim this injury occurred?_____
(month/day/year)

b. Date of diagnosis: _____
(month/day/year)

c. Name, address, telephone number and specialty of the person who diagnosed this injury: Beatriz Ibañez Pabón D.M.D. Endodoncist : San Germán Medical Plaza suite#201 HWY #2 K.17 San German PR 00683 (787)8921010 (787)892-1011

d. Name, address, telephone number and specialty of the person who treated this injury: Beatriz Ibañez Pabo'n D.M.D

_____

_____

3. Do you claim that you have suffered a psychological or emotional injury as a result of Fosamax use? Yes _____ No ✓

4. If the answer to the foregoing question is "yes," state the nature of the psychological or emotional injury or injuries which you claim.

___ Depression
___ Anxiety
___ Other (Please Specify): _____
___ Not claiming any psychological or emotional injury as a result of Fosamax use

a. When do you claim this injury occurred?_____
(month/day/year)

b. Have you sought treatment for this psychological or emotional injury? Yes ____ No ✓

c. Symptom(s):

_____

_____

d. Date(s) of onset: _____

e. Date of diagnosis: _____
(month/day/year)

f. Do you still have the injury? Yes ____ No _____

g. Name, address, telephone number and specialty of the person who first diagnosed this injury. _____

_____

_____

h. Name, address, telephone number and specialty of the person who treated this injury:_____

_____

_____

i. Medications prescribed or recommended:_____

_____

_____

j. Date(s) of treatment: _____

5. Have you had discussions with any physician(s), dentist(s), or other health care provider(s) about whether any injury described in section I(D) above is related to the use of Fosamax?

Yes _____ No ✓ I am a physician.

**If "yes,"** please identify:

Name(s) of health care provider(s):_____

Address(es):_____

Specialty:_____

Date(s) of Discussion(s):_____

a. Do you recall what you were told? Yes _____ No_____

b. **If "yes,"** what were you told? _____

_____

_____

_____

_____

**[If you discussed with more than one health care provider, please separately identify what each individual said to you]**

6. Do you claim that your treatment with Fosamax increased your risk of a future injury or harm that you have not yet experienced?
Yes ✓ No _____

**If "yes,"** identify and describe each and every such future injury or harm and for each, identify the basis for your contention._____

_____

_____

7. Have you had any discussions with any physician(s), dentist(s), or other health care provider(s) about whether your treatment with Fosamax or any other bisphosphonate puts you at increased risk of future injury or harm?
Yes _____ No ✓ Don't Recall _____

**If "yes,"** please identify:
Name of heath care provider(s):_____
Address:_____
Specialty:_____
Date(s) of Discussion(s):_____
State what the health care provider told you, including any description of the future injury or harm: _____

_____

_____

_____

_____

**[If you discussed with more than one health care provider, please separately identify what each individual said to you]**

8. If you do not claim to have suffered a physical, psychological, or emotional injury as a result of Fosamax use, state how you have been injured or damaged.

_____

_____

_____

## II. PERSONAL INFORMATION OF THE PERSON WHO USED FOSAMAX

A. Name: Tamari Reyes Hernandez

B. Maiden name(s) or any other name(s) by which you have been known (from prior marriages or otherwise, if any): _____

C. Gender: Male _____ Female ✓

D. Social Security number: 581213003

E. Driver's license number: 1169680 (Puerto Rico)
State of issuance: _____

F. Date and place of birth (city, county, and state): Humacao PR
January 3rd, 1960

G. Provide the full name, address, and age of each of your children: Jorge Iván García Reyes and Ivan Alejandro García-Reyes - 16 years - 18 years
Tomecillas 921 Alturas Mayaguez PR 00682-6223

H. Identify each address at which you have resided during the last ten (10) years, and list when you started and stopped living at each one:

| Address | Dates of Residence | |
|---|---|---|
| Tomecillas 921 Alturas Mayaguez | 7 years | 2000-Present |
| Rental home Bayamón? PR | 4 years | 1996-2000 |
| 10317 Bridgetown Place Burke | Va 7 years | 1989-1996 |

I. Complete the following information with respect to your employment for ten (10) years prior to your use of Fosamax or any other bisphosphonate to the present (If not employed during that period, state last employer).

| Employer | Address | Occupation/ Job Duties | Dates of Employment | Salary/ Bonus/ Overtime | |
|---|---|---|---|---|---|
| Bella Vista Hospital Mayaguez | Cerro las Mesas Mayagüez | physician Emergency Room | 1999 til present | 85,000 20,000 | +basic +overtime |

J. Within the last ten (10) years, have you been convicted of any felony or a crime involving dishonesty or false statement?
Yes _____ No ✓

**If "yes,"** please (1) identify the crime and/or felony, (2) when you were convicted or pled guilty, (3) where you were convicted or pled guilty, (4) whether you were incarcerated, and if so, for how long you were incarcerated.

_____

_____

_____

K. Are you making a claim for lost wages for either your present or previous employment? Yes ____ No ✓

**If "yes,"** identify your annual income at the time of the injury alleged in Section I(D): _____

L. Have you ever filed a lawsuit or brought any other type of legal claim aside from the present suit? Yes _____ No ✓

**If "yes,"** for each such lawsuit, state (1) the court in which such lawsuit was filed, (2) the case name, (3) the names of the adverse parties, (4) the civil action or docket number assigned to the lawsuit, (5) a description of your claims in the lawsuit, and (6) whether the lawsuit has been resolved and if so, how it was resolved._____

_____

_____

_____

M. Have you ever served in any branch of the U.S. Military? Yes ____ No ✓

**If "yes," please state:**

1. What branch and the dates of service:_____
2. Were you discharged for any reason relating to your physical, psychiatric or emotional condition? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
3. Have you ever been rejected from military service for any reason relating to your health or physical condition? Yes ____ No ____
   If **"yes,"** state what that condition was:_____
   _____
4. Have you ever served in the military overseas? Yes ____ No ____
   If **"yes,"** state location and dates:_____
   _____

N. Insurance / Claim Information

1. Have you ever filed a worker's compensation claim? Yes ____ No ✓
   **If "yes,"** to the best of your knowledge please state:
   a. Year claim was filed: _____
   b. Nature of disability: _____
   c. Approximate dates of disability: _____
   d. Resolution of claim: Denied ____ Granted ____ Other ____
      **If "other,"** describe: _____
   e. Identify the full name and address of the entity most like to have records concerning your claim: _____
   f. Full name and address of your employer against whom claim was filed:_____
      _____
2. Have you ever filed a social security disability (SSI or SSD) claim? Yes ____ No ✓
   **If "yes,"** to the best of your knowledge please state:
   a. Year claim was filed: _____
   b. Nature of disability: _____
   c. Approximate dates of disability: _____
   d. Resolution of claim: Denied ____ Granted ____ Other ____

**If "other,"** describe: _____

e. Identify the full name and address of the entity most like to have records concerning your claim: _____

_____

3. Has any insurance or other company provided medical and/or dental coverage to you (either directly or through a group or employer) for the period beginning twelve (12) years before your first use of Fosamax or any other bisphosphonate through the present? Yes _____ No V Don't Recall _____

**If "yes,"** then as to each such company, separately state:

a. Name of the company: _____

b. Address of the company: _____

_____

c. The account/policy number or designation: _____

d. Name of Primary Insured: _____

e. Dates of coverage: _____

f. It there are any insurance coverages for which you cannot recall all of the details, please describe those details that you can remember: ____

_____

_____

_____

## III. EDUCATIONAL HISTORY

Identify each school, college, university and other educational institution you have attended, the dates of attendance, courses of study pursued and diplomas or degrees awarded. Universidad Católica Madre y Maestra
1979 - 1985
Santiago Dominican Republic
Doctor of Medicine

## IV. FAMILY INFORMATION

A. Have you ever been married?
Yes V No _____

B. **If "yes,"** for each spouse/former spouse state:

1. Spouse's name: Iván D. García-Ramírez
2. Dates of marriage: Jan 1988 — 1999 divorced

3. Spouse's date of birth: November 29, 1959
4. Spouse's occupation: retired physician
5. Spouse's address and phone number: Campeche E-1 Ramirez arellano Mayaguez PR
6. If applicable, why did the marriage end (*e.g.*, divorce, death)? mutual agreement
7. If applicable, the date the marriage ended: 1999

C. Have your grandparents, parents, siblings and children ever had or been diagnosed with or had osteonecrosis or osteomyelitis?
Yes _____ No ✓

**If "yes,"** state (1) the name and relationship of the person to you, (2) the disease(s) he or she has/had, and (3) the date of that individual's diagnosis. ___

## V. DENTAL BACKGROUND

### A. HABITS

1. On average, during the twelve (12) year period BEFORE you first used Fosamax, how often did you:
   a. Brush your teeth per week? 28-30 times
   b. Floss your teeth per week? once
   c. See a dentist for routine check-ups, examinations or teeth cleaning? every 6 months

2. On average, during the period AFTER you began using Fosamax, how often do you:
   a. Brush your teeth per week? 28-30 times
   b. Floss your teeth per week? once
   c. See a dentist for routine check-ups, examinations or teeth cleaning? every 6 months

### B. DENTAL STATUS

1. Are you missing any teeth (including wisdom teeth or others)? Removed for braces
   Yes ✓ No _____ Don't Recall _____
   **If "yes,"** indicate the following:
   a. How many are you missing? 2
   b. Which teeth? wisdom teeth
   c. When and how did you lose each of those teeth? adolescence

2. Were any of the missing teeth extracted? Yes ✓ both No _____
Don't Recall _____

**If "yes," indicate the following:**

a. How many? 2

b. Which teeth? wisdom teeth

c. When and why were these teeth extracted? adolescence

d. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)). Dr. Oscar Muñiz Mayaguez
maxillo facial surgeon (787)833 1215
Doctors Center Building Mayaguez

3. Have you ever had any dental implants, artificial fixtures (including dentures and bridges), or any dental prosthodontics or orthodontia (including braces)? Yes ✓ No _____ Don't Recall _____

**If "yes," indicate the following:**

a. What type of dental implant(s), artificial fixture(s), or dental prosthodontics or orthodontia did you have? Braces

b. Identify approximately when you received each dental implant, artificial fixture, or dental prosthodontics or orthodontia? 2005

c. Please identify the teeth or the approximate locations in your mouth where you received dental implants, artificial fixtures, or dental prosthodontics or orthodontia? all teeth

d. Please provide the name, address, telephone number and specialty of the persons who installed or fitted your dental implants, artificial fixtures, or dental prosthodontics or orthodontia. Dr. Luis A. Perez-Rivera
Medical Building - De Diego
Mayaguez PR 00680
(787) 831 3555

e. Please describe any problems or complications you experienced relating to the dental implants, artificial fixtures, or dental prosthodontics or orthodontia you received? None

4. Have you ever had any periodontal procedures? Yes ____ No ✓
Don't Recall _____

**If "yes,"** indicate the following:

a. What type of periodontal procedure(s) have you had? None

b. When did you receive each procedure? _____

c. Please provide the name, address, telephone number and specialty of the person who performed each procedure. _____

d. Did you have any problems or complications related to the periodontal procedure (describe each complication)? _____

5. Have you ever had a fracture of the jaw? Yes ____ No ✓
Don't Recall _____

**If "yes,"** indicate the following:

a. Date(s) of each fracture? _____

b. Describe how you suffered each fracture? _____

c. Describe the portion(s) of the jaw fractured and the extent of the fracture(s): _____

d. Please provide the name, address, and telephone number of each person who treated you for each fracture. _____

C. Have you ever had or been diagnosed with any of the following conditions:

| | Yes | No | Unknown |
|---|---|---|---|
| Osteonecrosis of the jaw | ✓ | | |
| Osteomyelitis | | ✓ | |
| Infection in the mouth | | ✓ | |
| Tori in the mouth | | ✓ | |
| Bone spurs in the mouth | | ✓ | |
| Exposed bone in the mouth | | ✓ | |
| Tooth decay | | ✓ | |
| Poor healing of infections in the mouth | | ✓ | |
| Gum disease or infection | | ✓ | |
| Periodontal disease | | ✓ | |
| Bleeding gums | | ✓ | |
| Temporomandibular joint [TMJ] problems | | ✓ | |
| Abscesses | | ✓ | |

| | Yes | No | Unknown |
|---|---|---|---|
| Lesions in the mouth | | ✓ | |
| Cancer of the mouth | | ✓ | |
| Herpes [in or around the mouth] | | ✓ | |
| Lockjaw | | ✓ | |
| Exostosis (bony outgrowth) | | ✓ | |
| Pain (persistent or otherwise) in the mouth or jaw | ✓ | | |
| Swelling in the mouth or jaw | | ✓ | |
| Non-healing sore in the mouth or jaw | | ✓ | |
| Draining fistula | | ✓ | |
| Numbness of the lip, chin, mouth or jaw | | ✓ | |
| "Heaviness" of the jaw | | ✓ | |
| Burning or tingling in the jaw | | ✓ | |
| Limited range of motion in the jaw | | ✓ | |
| Edentulous (toothless) regions in the mouth | | ✓ | |
| Lingual Mandibular Sequestration | | ✓ | |
| Osteoradionecrosis | | ✓ | |
| Other disease of the jaw or oral cavity<br>Please specify: | ✓ | Micrognathia Congenital | |

D. If you responded "yes" to any of the above, please provide the following information for each condition:

| Condition | Name and Address of Person(s) Who Diagnosed or Treated the Condition | Approximate Onset Date of Condition |
|---|---|---|
| Osteonecrosis | Dra. Beatriz Ibañez D.M.D. | 10/24/2005 |
| | Endodontics | |
| | Sangerman Medical Plaza | |
| | Suite 201 San German PR | 00683 |
| | (787) 832 1010 | |
| | Fax (787) 892 1011 | |
| Micrognathia congenital | Dr. Oscar Muniz, Edificio Doctor Center, Mayaguez P.R. | 1970 |

E. State whether you ever had any of the following dental or oral procedures/tests at any time.

| | Yes | No | Unknown |
|---|---|---|---|
| Gingivectomy or gum resection | | ✓ | |
| Periodontal surgery | | ✓ | |
| Oral surgery | | ✓ | |
| Root canal or other endodontic procedure | | ✓ | |
| Root planing, scaling, or other treatment for gum disease | | ✓ | |
| Any invasive dental procedure | | ✓ | |

| | Yes | No | Unknown |
|---|---|---|---|
| Ridge smoothing | | ✓ | |
| Debridement of the oral cavity | | ✓ | |
| Bone trimming | | ✓ | |
| Apicoectomy | | ✓ | |
| Bone jaw biopsy | | ✓ | |
| Dental x-rays, panorexes, or other dental imaging | | ✓ | |
| Other diagnostic test or imaging of the mouth or jaw Please specify: age 20 (1970) | mandibular surgery for micrognathia | | |

F. For each procedure/test for which you answered "yes," please identify the following information:

| Test/Procedure | Name and Address of Physician/Dentist Who Performed Test/Procedure | Approximate Dates of Treatment |
|---|---|---|
| Micrognathia | Oscar Muñiz Echevarría | 1970 |
| | Maxillofacial Surgeon | |
| | (787) 833 1215 | |
| | Doctor's Center Building | |
| | Mayaguez PR | |
| | P.O. Box 37 Mayaguez PR | 00681 |

## VI. OTHER MEDICAL BACKGROUND AND INFORMATION

A. To the best of your knowledge, did you use or take any of the following medications or substances BEFORE the injury that you allege you suffered occurred? If "yes," please provide the first and last date on which you took the medication or substance.

| | Yes | No | Date First Taken | Date Last Taken |
|---|---|---|---|---|
| Corticosteroids or other steroids | | ✓ | | |
| Radiation therapy | | ✓ | | |
| a. Head and/or Neck | | ✓ | | |
| b. Other Body Part | | ✓ | | |
| Chemotherapy | | ✓ | | |
| Hormonal therapy (including, but not limited to, estrogen therapy, oral contraceptive, estrogen/progestin therapy, anti-estrogens, aromatase inhibitors, and anti-androgens/androgen deprivation therapy) | ✓ | | | from 2000 until present due to Histerectomy |

| | Yes | No | Date First Taken | Date Last Taken |
|---|---|---|---|---|
| Blood pressure (hypertension) medication | | ✓ | | |
| Cholesterol-lowering medication | | ✓ | | |
| Medication for the treatment of Rheumatoid Arthritis | | ✓ | | |
| Medication for the treatment of Diabetes | | ✓ | | |

B. Were you taking any other prescription medicines in the five (5) years prior to developing the injury you are claiming in this action?
Yes _____ No ✓

**If "yes,"** please list the medications, the first and last dates of ingestion, and reasons for taking each. _____
_____
_____

C. Have you participated in any clinical trials or taken any experimental drugs?
Yes _____ No ✓

**If "yes,"** please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs. _____
_____
_____
_____
_____

D. Smoking/Tobacco Use History:

Do you now or have you ever smoked or used tobacco products?
Yes_____ No ✓
**If "yes,"** indicate with an "X" the answer and fill in the blanks applicable to your history of smoking and/or tobacco use

1. Current smoker of cigarettes ____; cigars ____; pipe tobacco ____; or user of chewing tobacco/snuff ____.
   a. Amount smoked or used: on average _____ per day for _____ years.
2. Past smoker of cigarettes ____; cigars ____; pipe tobacco ____; or used chewing tobacco/snuff ____.
   a. Date on which smoking/tobacco use ceased: _____
   b. Amount smoked or used: on average _____ per day for _____ years.

E. Alcoholic Beverage Consumption History

Do you now drink or have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes ✓ No ____
**If "yes," fill in the appropriate blank with the number of drinks that represents your average alcohol consumption during the period you were taking Fosamax up to the time that you sustained the injuries alleged in the complaint:**

____ drinks per week,
1 drinks per month, occasional cup of red wine.
____ drinks per year, ***or***

Other (describe): _____

F. Have you ever experienced or been diagnosed or treated for any of the following:

| | Yes | No | Unknown |
|---|---|---|---|
| 1. Necrosis, avascular necrosis, aseptic necrosis or osteonecrosis in any part of the body | | ✓ | |
| 2. Osteoporosis | | ✓ | |
| 3. Paget's disease | | ✓ | |
| 4. Pancytopenia or abnormal blood count secondary to cancer and/or cancer treatment | | ✓ | |
| 5. Sickle cell disease | | ✓ | |
| 6. Gaucher's disease | | ✓ | |
| 7. Vascular diseases, problems, or insufficiencies | | ✓ | |
| 8. Autoimmune or connective tissue disorders | | ✓ | |
| a. Systemic lupus erythematosus | | ✓ | |
| b. Rheumatoid arthritis | | ✓ | |
| c. Vasculitis | | ✓ | |
| d. Crohn's disease | | ✓ | |
| e. Reynaud's syndrome | | ✓ | |
| f. Sjogren's syndrome | | ✓ | |
| g. IBD (Inflammatory Bowel Disease) | | ✓ | |
| h. Pernicious Anemia | | ✓ | |
| i. Primary Biliary Cirrhosis | | ✓ | |
| j. Other (describe): _____ | | ✓ | |
| 9. Acquired Immune Deficiency Syndrome (AIDS) or HIV | | ✓ | |
| 10. Renal transplant, disease and/or impairment | | ✓ | |
| 11. Caisson's disease,barotraumas and/or decompression sickness | | ✓ | |
| 12. Pancreatitis | | ✓ | |
| 13. Diabetes Mellitus | | ✓ | |
| 14. Fungal infections (including, but not limited to, Aspergillis fungus) | | ✓ | |
| 15. Asthma | | ✓ | |
| 16. Blood disorders, dyscrasias or other blood abnormalities | | ✓ | |
| 17. Dislocation of any bones in the jaw | | ✓ | |
| 18. Bone disorders and/or fractures | | ✓ | |
| 19. Herpes Zoster | | ✓ | |

| | Yes | No | Unknown |
|---|---|---|---|
| 20. Any other liver or kidney disease(s) not mentioned above. Please specify: gall bladder stones cholecystectomized 2006 | ✓ | | |

G. If you responded "yes" to any of the above, please provide the following information for each condition:

| Condition | Name and Address of Person(s) Who Diagnosed or Treated Condition | Approximate Onset Date of Condition |
|---|---|---|
| gallbladder stones | Dr. Juan Suris General Surgeon Mayagüez PR | 2006 |
| | | |
| | | |
| | | |
| | | |
| | | |

H. If you are claiming a psychological or emotional injury in this case, state whether you have ever experienced or have ever been treated for any psychological, psychiatric or emotional problem (including depression) not related to your use of Fosamax.

Yes _____ No ✓

**If "yes,"** please provide the following information for each condition:

1. Describe the symptoms experienced. _____
2. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment. _____
3. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____
4. For each provider of care identified in subparagraphs 2 and 3, please produce an executed copy of the release form attached as Ex. C, authorizing Merck to obtain your psychotherapy notes and related records generated by any such mental health care practitioner.

I. Have you ever suffered any injury to your head, neck, mouth or jaw?
Yes _____ No _____

**If "yes,"** please state:

1. When the injury occurred. _____
2. The nature of the injury, including what part of the body was injured. _____

3. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment._____
_____
_____

4. Please provide the name and address of the facility or hospital, if any, where the treatment was provided. _____
_____
_____

5. Please identify the medications taken to treat the injury. _____
_____
_____

## VII. CANCER BACKGROUND

A. Have you ever been diagnosed with cancer or metastatic disease?
Yes _____ No ✓

**If "yes":**

1. When were you first diagnosed with cancer or metastatic disease?
_____

2. What type of cancer or metastatic disease was it? _____
_____

3. Who diagnosed this cancer or metastatic disease? (Please provide the name, address, telephone number and specialty of each diagnosing physician). _____
_____
_____

4. Have you been diagnosed with cancer or metastatic disease more than once? Yes _____ No _____

**If "yes,"** provide the information requested in questions 1, 2, and 3 for each cancer or metastatic disease diagnosed. _____
_____
_____
_____

## VIII. FOSAMAX AND OTHER BISPHOSPHONATE USE

A. Identify which of the following medications you have taken:

| | | Yes | No |
|---|---|---|---|
| 1. | FOSAMAX® | ✓ | |
| 2. | FOSAMAX PLUS D® | | ✓ |
| 2. | Zometa® | | ✓ |
| 3. | Aredia® | | ✓ |
| 4. | Actonel®: | | ✓ |
| 5. | Boniva® or Bondronat® | | ✓ |
| 6. | Didronel® | | ✓ |
| 7. | Skelid® | | ✓ |
| 8. | Nerixia® | | ✓ |

| | | Yes | No |
|---|---|---|---|
| 9. | Bonefos® or Clastoban® or Clasteon® or Ostac® | | |
| 10. | Osteolite® | | |

B. Complete the following information for each drug identified above:

| Dates of Use of Drug (month/ day/year) | Dosage and Form of Dose (IV, oral) | Full Name of Physician(s) Who Prescribed | Full Address of Prescribing Physician(s) | Condition(s) Treated | Name of Facility and Street Address of Location Where Drug Was Infused, Injected or Taken or Name and Address of Pharmacy(s) Where Prescription was Filled |
|---|---|---|---|---|---|
| Fosamax 11/05/04 | 35 mg & 70 mg | Dr. Tammy Reyes Sup. Prescribed it She is a Physician | | Prevent osteoporosis | Walgreens #3174 2097 Ave. Hostos Mayaguez PR 00682 |
| | | | | | |
| | | | | | |

C. For what disease or condition were you prescribed each of the medications identified in section VIII(A):

1. Injury, illness, or disability: had an historactomy and wanted to prevent osteoporosis
2. Date(s) of onset: Historactomy - 2000
3. Date(s) of diagnosis: Historactomy - 2000, no diagnosis Just a Precaution
4. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. No diagnosis, precaution to prevent osteoporosis
5. List the treatment (surgery, medications taken or prescribed) for the injury, illness or disability. N/A

D. Did you receive any samples of Fosamax? Yes ✓ No ____

**If "yes," provide the following:**

1. Identify the full name and address of each person who provided them: Client can't recall

2. Identify the approximate date(s) when the samples were provided: between 5/03 - 8/03

E. At the time you first began taking Fosamax or other bisphosphonates did you suffer from any other physical injuries, illnesses or disabilities other than the disease or condition identified in VIII(C) above? Yes ____ No ✓

**If "yes," identify the injury, illness, or disability, symptoms, date(s) of onset and dates(s) of diagnosis**

1. Injury, illness, or disability:_____

2. Symptom(s):_____

3. Date(s) of onset:_____

4. Date(s) of diagnosis:_____

5. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____

F. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries BEFORE the injury you allege you suffered occurred.

| | Yes | No | Unknown |
|---|---|---|---|
| 1. Skeletal bone scan (scintigraphy), Dual Energy X-Ray Absorptiometry (DEXA) scan, or nuclear medicine imaging | | ✓ | |
| 2. MRI (including functional MRI, or MRI spectroscopy), CT or CTA scans for bone | | ✓ | |
| 3. Doppler scans | | ✓ | |
| 4. Ultrasound for bone | | ✓ | |
| 5. PET scans for bone | | ✓ | |
| 6. Interventional radiology procedure images, such as organ procedures or vascular interventional radiology procedures | | ✓ | |
| 7. Vascular surgery | | ✓ | |
| 8. Any other surgery on bone (Please describe: _____) | | ✓ | |

G. For each test, procedure, or surgery for which you answered "yes," please identify the treating physician and approximate date of the test.

| Test/Procedure | Name and Address of Facility Where Test/Procedure Performed | Approximate Dates of Test/Procedure |
|---|---|---|
| | | |
| | N/A | |
| | | |
| | | |
| | | |

H. Did you see any written, televised or internet-based advertising or labeling materials regarding Fosamax prior to or during the time you took Fosamax? Yes ✓ No _____

**If "yes,"** state which written, televised or internet-based advertising or labeling materials you recall seeing regarding Fosamax and when you saw such advertising or labeling materials, excluding any such materials that are covered by the Attorney-Client or Work Product Privileges. package insert. + PDR information

I. Have you ever visited any website (including any chat rooms) regarding Fosamax or any other bisphosphonates? Yes _____ No ✓

**If "yes,"** identify all websites and chat rooms visited that you recall and the approximate dates of visit, excluding any such visits that are covered by the Attorney-Client or Work Product Privileges.

J. Instructions or Information:

1. Did you receive any written or oral instructions or information about Fosamax before you took it? Yes ✓ No ____ Don't Recall _____
2. **If "yes,"** please answer the following:
   a. When did you receive the instructions or information? package insert
   b. From whom did you receive it? Walgreens
   c. What written instructions or information did you receive? Early morning, empty stomach, stay up 30 minutes, full glass of water
   d. What oral instructions or information did you receive? No

## IX. MONETARY LOSS CLAIMS

A. Have you paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax and for which you seek recovery in the action you have filed?

Yes ✓ No _____

**If "yes,"** state the total amount of such expenses at this time: $ 2,000.00

B. Has your insurer, or any other entity or person, paid or incurred any medical expenses that are related to any condition that you claim or believe was caused by your use of Fosamax and for which you seek recovery in the action you have filed?

Yes ✓ No _____

**If "yes,"** state the total amount of such expenses at this time: $ 1,000.00

Please provide an itemized statement of the nature and amount of all damages you are claiming. 3 root canals
3 crowns

## X. WITNESSES

Please identify all persons (not identified elsewhere in this questionnaire) who you believe possess information concerning your injury, your current medical condition, the medical condition for which you took Fosamax, and/or your claims in this case and for each, state their name, address, telephone number and a description of the information you believe they possess.

N/A

## XI. DOCUMENTS AND THINGS

Please indicate whether you or your attorney are in possession of the following documents by checking "Yes" or "No" where indicated and attach copies of the following documents to your response to this profile form. If you withhold a document or information otherwise discoverable by claiming that it is privileged or otherwise protected, you shall make any such claim expressly and describe the nature of the information or document not produced or disclosed in a manner that enables other parties to assess the applicability of the privilege or protection, in accordance with the requirements of Fed.R.Civ.P. 26(b)(5).

A. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical or

dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached to this Plaintiff's Profile Form as Ex. A, authorizing Merck to obtain medical records from each health care practitioner.

B. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from each health care practitioner who later becomes known to Merck who has examined you, treated you, or consulted with other health care practitioners regarding your medical or dental condition at any time.

C. For each hospital, clinic or any other facility at which you have been treated for any medical or dental condition within twelve (12) years of your first use of Fosamax to the present, produce an executed copy of the release form attached as Ex. A, authorizing Merck to obtain medical records from each such hospital, clinic or any other facility.

D. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing Merck to obtain medical records from any hospital, clinic or any other facility that later becomes known to Merck and at which you have been treated for any medical or dental condition at any time.

E. Has any health care practitioner examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at or in affiliation with a Veteran's Administration facility?
Yes_____ No ✓

If your answer is YES, please produce an executed copy of the release form VA 10-5345 attached as Ex. B, authorizing Merck to obtain medical records from each health care practitioner.

F. Has any psychologist, psychiatrist or other mental health care practitioner examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Fosamax? Yes_____ No ✓

If your answer is YES, please produce an executed copy of the release form Authorization for Release of Mental Health Records attached as Ex. C, authorizing Merck to obtain your mental health records, psychotherapy notes, and clinical information generated by any such mental health care practitioner.

G. A copy of all medical records from any health care provider identified in any of your responses to the questions above. Yes ✓ No ____

H. All radiological or other imaging or recordings identified in any of your responses to the questions above. Yes ✓ No ____

I. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding. Yes ____ No ____ N/A

J. Have you ever made a claim for Social Security benefits, disability insurance benefits, or workers' compensation benefits? Yes_____ No✓

If your answer if YES, please produce an executed copy of each applicable authorization (Form SSA-3288; Authorization for Release of Disability Insurance Records; and/or Authorization for Release of Workers' Compensation Records) attached as Ex. D, authorizing Merck to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits.

K. If you claim you have suffered a loss of earnings or earning capacity, produce copies of your Federal and State income tax returns and related tax forms (such as W-2s, 1099's, etc.) evidencing all income for each of the years from ten (10) years prior to your injury to the present. Yes ____ No ✓

L. Do you claim you have suffered a loss of earnings or earning capacity? Yes_____ No✓

If your answer is YES: please produce executed copies of each of the authorizations (Form 4506 and Authorization for Release of Department of Revenue Records) attached as Ex. E, authorizing Merck to obtain your Federal and State income tax returns for each of the years from ten (10) years prior to your injury to the present.

M. If your answer to Question L is YES, please also produce an executed copy of the authorization Form SSA 7050-F4 attached as Ex. F, authorizing Merck to obtain your earnings information from the Social Security Administration.

N. If you claim you have suffered a loss of earnings or earning capacity, all documents relating to your employment at any time, including documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda. Yes ____ No ✓

O. If your answer to Question L above is YES, for each of your employers identified in any of your responses to the questions above, please produce two executed copies of the release form Authorization for Release of Employment Records attached as Ex. G, permitting Merck to obtain your employment records, including W-2 forms.

P. Have you ever served in the military? Yes_____No✓

If your answer is YES, please produce an executed copy of Standard Form 180 attached as Ex. H, permitting Merck to obtain your military personnel, service, and health records.

Q. Copies of all documents from any healthcare provider (as defined above) or others discussing, describing, relating to, or memorializing your treatment with Fosamax or to any condition you claim is related to the use of Fosamax. Yes ✓ No ____

R. For each insurance company or other organization that has insured you from twelve (12) years prior to your first use of Fosamax to the present, produce an executed copy of the authorization, attached as Ex. I, authorizing Merck to obtain all insurance records from each such company.

S. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, handouts or other materials distributed with or provided to you in connection with your use of Fosamax. Yes ✓ No ____

T. Copies of advertisements, written or Internet materials or promotions for Fosamax which you saw prior to or during your use of the medication. Yes ✓ No ____

U. Copies of all websites you visited regarding Fosamax or any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____ N/A

V. Copies of transcripts of Internet chat room discussions in which you participated regarding Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____ N/A

W. Copies of email relating to Fosamax, any other bisphosphonates, your injuries and/or this lawsuit, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ____ No ____ N/A

X. All documents relating to Fosamax or any alleged health risks or hazards related to these drugs in your possession at or before the time of the injury alleged in your Complaint. Yes ✓ No ____

Y. All documents you (and not your lawyer) obtained directly or indirectly from Merck. Yes ✓ No ____

Z. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ✓ No ____

AA. All diaries, calendars or any other writings or recordings made by you, or by any other person, describing, discussing, explaining or referring to the underlying illness or disease for which you received Fosamax, not including those items covered by the Attorney-Client or Work Product Privileges. Yes ✓ No ____

BB. Copies of all documents you (and not your attorneys) obtained from any source related to Fosamax or to the alleged effects of such medications, not including those items covered by the Attorney-Client or work Product Privileges.
Yes ✓ No ____

CC. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.
Yes ✓ No ____

DD. Decedent's death certificate (if applicable).
Yes ____ No ____ Not applicable ✓

## XII. LIST OF MEDICAL PROVIDERS AND OTHER SOURCES OF INFORMATION

***Identify the following:***

A. Your current family and/or primary care physician:

| Name | Address | Specialty | Approximate Dates of Treatment |
|---|---|---|---|
| Ismael Velazquez | PO Box 1939 Cabo Rojo 00623 | Internal Medicine | 2000 - cellulitis Big toe |

I have been healthy thereafter

B. Identify each of your *other* primary care physicians for the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

| Name | Address | Specialty | Approximate Dates of Treatment |
|---|---|---|---|
| ~~Dr~~ | PO Box 4551 | OBGyn | 2000 |
| Jimenez Cruz Jose | Mayaguez | | Histerectomy |
| | | (787)833 | 2250 |

C. Each hospital, clinic, or healthcare facility where you have received inpatient treatment or been admitted as a patient during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

| Name | Address | Admission Dates | Reason for Admission |
|---|---|---|---|
| Bella Vista Hospital | Carr Mesa Mayagüez | 2000<br>2006 | Cellulitis, Big toe histerectomy<br>Cholecystectomy |
| PO Box | 1750 Mayagüez PR | 00681-1750 | |

D. Each hospital, clinic, or healthcare facility where you have received outpatient treatment (including treatment in an emergency room) during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

| Name | Address | Treatment Dates | Reason for Treatment |
|---|---|---|---|
| Tamari Reyes MD (Self Treated) | Torrecillas 92 Altos Mayagüez PR | 2005 | Surgical Menopause |
| | | | |

E. Identify each health care provider who has ever seen or treated you for osteoporosis or the underlying illness for which you took Fosamax.

| Name | Address | Specialty | Approximate Dates of Treatment |
|---|---|---|---|
| Tamari Reyes (Self Treated) | Torrecillas 92 Altos Mayagüez PR 00682 | Gyneco Med | |
| | | | |

F. Each dentist, orthodontist, periodontist, oral and maxillofacial surgeons or other healthcare provider involved in providing dental care or treatment who you have ever seen or from whom you have ever received treatment.

| Name | Address | Specialty | Approximate Dates of Treatment |
|---|---|---|---|
| Ana L. Ramos<br>22 Morell Campos | Bo Barcelona Mayagüez | Dentist<br>(787) 265 3918 | 2000-2005 |
| Carter Torres Sonia | Edif. Medico profesional | Dentist Mayagüez | 787 832 8966<br>Year 2006-2007 |
| | | | |

| | | | |
|---|---|---|---|
| | | | |

G. Identify any other healthcare provider by whom you have been seen or from whom you have received treatment for any reason during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

| Name | Address | Specialty | Approximate Dates of Treatment |
|---|---|---|---|
| none other than the listed already | | | |
| | | | |
| | | | |

H. If you are claiming any psychological or emotional damages, identify each psychiatrist, psychologist, mental health counselor, therapist and/or social worker from whom you have received treatment or with whom you have consulted regarding your health during the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present. N/A

| Name | Address | Specialty | Approximate Dates of Treatment |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

I. Each pharmacy that has dispensed medication to you in the twelve (12) years prior to the date of your first use of Fosamax or any other bisphosphonate through the present.

| Name | Address |
|---|---|
| Pharmacy = Walgreens | Hwy 2 College Plaza Malaga (787)805 4805 |
| | |
| | |

**DECLARATION**

I declare under penalty of perjury subject to 28 U.S.C. § 1746 that all of the information provided in this Plaintiff Profile Form is true and correct to the best of my knowledge, I have supplied all the documents requested in part XI of this Profile Form to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and I have supplied the authorizations attached to this declaration.

| Signature | Print Name | Date |
|---|---|---|
| Tamari Reyes Hernández | Tamari Reyes Hernández | 7-11-2007 |

BA2/306801